Printed: 11/05/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/ AND PLAN OF CORRECTION IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		175385		B. WING		11/05	/2015
NAME OF PR	OVIDER OR SUPPLIER PARK		200 SW	ESS, CITY, STAT 14TH N, KS 67114			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	3		F 000			
	The following citations represent the findings of a Health Resurvey.						
	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS			F 159			
	facility must hold, saf		nt				
	The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)						
	funds that do not exc	ntain a resident's perso eed \$50 in a non-intere rest-bearing account, o	est				
	The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.						
	The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.						
	The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.						
LABORATOR	Y DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIV	'E'S SIGNATURE		TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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		175385		B. WING		11/0	05/2015
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE		
ASBURY	PARK		200 SW NEWTO	14TH N, KS 6711	4		
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F 159	the resident's account SSI resource limit for section 1611(a)(3)(B) amount in the account the resident's other not reaches the SSI resourcesident may lose eliginary for the facility had a centary managed funds for 23 interview and record robtain written authorized funds for 1 resident (#accounts reviewed. Findings included: On 10/29/14 at 4:30 trust fund account reviewed. Findings included: On 10/29/14 at 4:30 trust fund account reviewed edger revealed staff in \$70.00 balance brough previous year's (2014 facility had managed some time. On 10/29/15 on 3:30 stated the facility becatary funds at the administrative staff Dobtain a written author resident's monies.	y each resident that nefits when the amount treaches \$200 less that one person, specified i of the Act; and that, if the tit, in addition to the value onexempt resources, arce limit for one person gibility for Medicaid or Sunot met as evidenced to sus of 97 residents and 3 residents. Based on review, the facility failed exaction prior to managing the view of the resident from the control of the resident's control of the resident's control of the resident's control of the resident's manage the view of the resident's monies for the resident's monies for the payee for resident time. At that time, verified the facility failed the facility fai	an the n the n the le of	F 159			

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	OVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE SW 14TH					
ASBURY	PARN			ON, KS 6711	4				
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F 159	written authorization of manage the funds of with the organization. deposited into an acca resident personal fur form must be completed. The facility failed to opinior to managing the which the facility had	blain written authorization for this resident, and signed.	sited n be der, ion	F 159					
F 253 SS=E	483.15(h)(2) HOUSEKEEPING &		a	F 253					
	This Requirement is not met as evidenced by: The facility reported a census of 97 residents, who resided on 8 nursing units. Based on observation and interview, the facility failed to provide effective housekeeping and maintenance services for 43 residents on 2 of the 8 nursing unit's beauty shop and residents common living area.		o ance g						
	Findings included: - Observation, on 10-27-15 at 8:30 am, with maintenance staff B, revealed the beauty shop								
	contained the following areas of concern: 1. The shampoo bowl hose contained corroded discolored metal plumbing components, and spigot with grime and the build-up of a black substance. 2. The step on trash can, contained grime across								

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F 253	3 Continued From page 3 the exterior. 3. Four hair dryers contained a large			F 253			
	accumulation of a white substance (lint/dust) on the filters and dust on the upholstery.						
	4. Three, gallon size containers, of hair care products contained hair and grime across the exterior surfaces of the containers. Also 8 smaller bottles of hair care products of varying sizes contained hair and sticky discolored substances across the exteriors of the containers.						
	5. The shelves of a bookcase, which contained various hair care products, contained a layer of dust and grime.						
		drawer unit, contained perm papers with gr					
	7. The air vent on the of dust and hair.	e floor contained a build	i-up				
	black scuff marks and	d multiple scrapes with I the floor perimeter lation of grime and hair					
	9. The chair by the shampoo bowl contained an accumulation of white grime, and the mat beneath the chair contained grime and hair build-up.		d an				
	Interview, on 10-27-15 at 8:30 am, with maintenance staff B, confirmed the above observations. Staff B stated he/she needed to put the beauty shop floors on a routine cleaning schedule.						
		5 at 10:30 am, with hou aled the housekeepers	ıse				

` ,		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		A. BUILDING		(X3) DATE SURVEY COMPLETED	
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F 253	should be responsible floors. The facility agreement dated 9-23-11, ensur a suitable space for the which conformed to rand make changes to environment. The undated facility pheld these 2 nursing failed to indicate any area. Furthermore, during the sum of the su	nt for cosmetology serviced the facility would prohe provision of services meet regulatory requirer or maintain the physical coolicy for (the building wounts) cleaning schedul cleaning of the beauty the environmental tour anance staff B, (1 of the building), revealed the common living areas ains ranging from 2 inches. Stated, at this time, that the nursing unit's carped it's dining area, contain black scruff marks and the floor by the kitchen on, Maintenance staff E have a floor care provice the maintenance service the maintenance services.	ces, ovide sments which e, shop at 2 arpet the black der ces in ed 2 a of	F 253			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPI AND PLAN OF CORRECTION IDENTIFICATION N		(X1) PROVIDER/SUPPLIER/C			LE CONSTRUCTION	(AS) DATE SO	
AIND PLAIN UI	CORRECTION		IX.	A. BOILDING		COMPLE	ובט
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F 253	The (building with 2 n cleaning schedule, lad floor/carpet cleaning, maintenance of deficient the facility failed to promaintenance services this building) with 43 n beauty shop, elevator	ursing units) undated, cked guidance for but advised staff to not encies in the building. Tovide housekeeping are for these 2 nursing unitesidents, to maintain the, and the 2 nursing unitesidents.	nd its (in ne	F 253			
F 257 SS=E				F 257			
	This Requirement is not met as evidenced by: The facility reported a census of 97 residents, with 43 who resided on 2 nursing units. Based on observation and interview, the facility failed to provide a comfortable temperature for the 43 residents of these 2 nursing units. Findings included: - On 10/27/15 various residents who resided on the 2 nursing units in 1 building, revealed complaints of being too cold in the facility as follows:		ed on o				
	follows: Interview, on 10-27-15 at 12:34 pm, with resident #59 revealed he/she felt it was always cold in his/her room and in the lobby area. The resident reported he/she thought there was only a central control for the facility heating/cooling.						

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL ID PLAN OF CORRECTION IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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F 257	#103, revealed he/shroom, and wore hear covered him/herself felt the facility still hat he/she had no way to the facility still hat he/she had no way to the facility still hat he/she had no way to the facility still hat he/she had no way to the facility still hat he/she had no way to the facility on the resident's room control being to on the resident's room control being to on the resident's room control being to on the resident's room. The resident is a shower. The temp time recorded as 68. Interview, on 10-27-felt would be cold afterwing in the shower. The temp time recorded as this time recorded as Interview, on 10-29-care staff L, revealed regulate the temperate this time. The temperate this time. The the living areas on the 2 building) was set at Staff B explained the units in their individual position to stop the control of the facility of th	15 at 2:06 pm, with residue felt is was cold in their by clothes, socks and with blankets. The residue the air conditioner on a control the cool air. 15 at 2:40 pm, with residuelt felt cool air in spite of the transport of the cool air.	dent and dent ne cure 1.8 dent and dent er take nis dent and ne while at eit. et s. with ed a don in t. ng e "off" n	F 257			

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NAME OF PROVIDER OR SUPPLIER ASBURY PARK B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 200 SW 14TH	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/ AND PLAN OF CORRECTION IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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NEWTON, KS 67114				200 SW	14TH			
PREFIX (FACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX (FACH CORRECTIVE ACTION SHOULD BE	PRÉFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATOR) OR LSC IDENTIFYING INFORMATION)			PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	LD BE	(X5) COMPLETION DATE
F 257 Continued From page 7 any warm air at this time. The facility undated policy for the Boiler/Chiller, advised staff of the Vice President of Support Services to manipulate the boiler and chiller systems in (the building with 2 nursing units) to maintain the temperature to meet the environmental standards and comfort of the residents receiving care in (these 2 nursing units). The facility failed to ensure the provision of comfortable temperatures for the 43 residents who reside in these 2 nursing units in this building. F 280 483.20(d)(3), 483.10(k)(2) RIGHT TO F 280 A83.20(d)(3), 483.10(k)(2) F 280 A83.20(d)(3), 483.10(k)(F 280	any warm air at this to The facility undated produced staff of the V Services to manipula systems in (the building maintain the temperate environmental standaresidents receiving carecidents and resident has the incompetent or other incapacitated under the participate in planning changes in care and A comprehensive assessinterdisciplinary team physician, a registere for the resident, and disciplines as determined, to the extent produced the resident, the resident revised by a tear each assessment.	colicy for the Boiler/Chilice President of Supporte the boiler and chiller ng with 2 nursing units atture to meet the ards and comfort of the are in (these 2 nursing three for the 43 resident nursing units in this are in the same the provision of tures for the 43 resident nursing units in this are in the same the provision of tures for the 43 resident nursing units in this are in the same that in the same that includes the attered nurse with responsibility of the participation of the proportion of the sament; prepared by any that includes the attered nurse with responsibility of the resident's family or the reside	et to to units). ts ced anding ility and eeds, con of dent's eed ifter				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/ AND PLAN OF CORRECTION IDENTIFICATION NUMB			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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F 280	The facility had a censample included 23 roobservation, record refacility failed to review sampled residents cabehaviors, (#65) with (#2 and #60) for falls, Findings included: Review of resident orders, dated 10/8/15 readmitted on 8/25/15 diagnosis included; a reaction characterize uncertainty and irratic (sudden severe conformestlessness), and dedisorder characterize confusion). The admission MDS 6/10/15, revealed the interview for mental smoderately impaired delirium, inattention a with the behavior preresident with a mood minimal depression. Behavioral symptoms rejection of care, and 1-3 days. The resider assistance for ADL's resident received and The CAA (care area afor cognition, docume admission with a diagstatus and demonstrations.	sus of 97 residents. The esidents. Based on eview, and interview, the vand revise 5 of the 23 are plans including; (#27 urinary indwelling cathor, and (#33) with side rains, are vealed the resident 5, with the following nxiety (mental or emotion of the properties	e 7) for eter, ls. onal irium dental	F 280			

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F 280	behaviors, the care to the resident can be voor The quarterly MDS, or resident had a BIMS cognition; physical be toward others, and the days. The resident reassistance for transfer hygiene. The resident and antianxiety media. The care plan, review the resident had impart of Alzheimer's (progrecharacterized by condementia, and the resident to processimple "yes/no" questing the resident was at mood due to recent of and impaired cognitions taff to contact the performation of the care the trending and monitoring the care plan lacked interventions for this antipsychotic and and The nursing progress documented the resident was documented the resident was at the care plan lacked interventions for this antipsychotic and and The nursing progress documented the resident was at the care plan lacked interventions for this antipsychotic and and the care plan lacked interventions for this antipsychotic and and the care plan lacked interventions for this antipsychotic and and the care the care plan lacked interventions for this antipsychotic and and the care plan lacked interventions for this antipsychotic and and the care plan lacked interventions for this antipsychotic and and the care plan lacked interventions for this antipsychotic and and the care plan lacked interventions for this antipsychotic and and the care plan lacked interventions for this antipsychotic and and the care plan lacked interventions for this antipsychotic and and the care plan lacked interventions for this antipsychotic and and the care plan lacked interventions for this antipsychotic and and the care plan lacked interventions for this antipsychotic and and the care plan lacked interventions for this antipsychotic and antipsychotic antipsychotic and antipsychotic antipsychotic antipsychotic antipsychotic antipsychotic antipsychotic antipsy	racker charting docume erbal and "reject" cares and "reject" cares dated 9/8/15, revealed to score of 13, indicating the score of 13, indicating the behavior allowed or sequired limited staff ers, toilet use, and perset received an antipsychication. Inved on 9/15/15, docume aired cognition; a diagnostic essive mental deterioral fusion and memory fails sident's short/long term uate. The care plan essive mental deterioral fusion and memory fails sident's short/long term uate. The care plan essive mental ess, and to provide times things cognitively; use tions. The care plan instructions. The care plan instructions and murses note in living environs arcker and nurses note in the care plan instruction. The care plan instruction continued to document and the section of the care plan instruction. The care plan instruction and the document of the care plan instruction. The care plan instruction and the document of the care plan instruction. The care plan instruction and the care plan instruction. The care plan instruction. The resider discontinued due to a interaction. The resider discontinued due to a interaction. The resider	he intact ected in 1-3 onal notic ented osis tion ture) e for sing aired nament cuted ered ment is for sing in for sing in formation in the cuted ered ment is for exercising, the cuted ered in the cuted ered in the cuted ered ered in the cuted ered ered ered ered ered ered ered e	F 280			

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F 280	following physician or (antipsychotic medica 1 by mouth twice dail (antidepressant medical every AM to target anneeded Ativan (antian 1 by mouth every 6 hanxiety. The AIMS (abnormal score) dated 10/2/15, was without any abnormal score) dated 10/2/15, reveals any behaviors. Review of the Composition	rders, to increase Serocation), to 25 mg (milligray, add Celexa cation), 10 mg, 1 by monxiety, and increase as exiety medication) to 0. ours PRN (as needed) involuntary movement, documented the reside	ent for hout h15, 59 d not t any ed the ed. The alked e s. ed the ining a	F 280			

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F 280	stated he/she had no physical with staff or were documented by aides) in the Kiosk (documentation) and know. When the resident outalk with him/her, the On 10/29/15 at 3:50 the resident would cowould yell for help. To someone with him/her little 1 on 1 and the care staff T stated heresident's behaviors the nurse. On 10/29/15 at 3:15 stated the resident would here in the nurse of the resident would the nurse. On 10/29/15 at 3:15 stated the resident would the resident would the nurse of the resident would be a staff S stated the resident was alerted to the resident on 10/30/15 at 1:13 staff A explained that responsible to update on 10/30/15 at 1:13 staff Q stated the resident was alerted to the resident was all the resident was alerted to the resident was all the resident was alerted to the resident was all the resident was all the residen	ever known the resident another resident. Beha to the CNAs (certified nur CNA electronic the CNAs would let the ident became anxious, if with the other resident e resident would be fine. PM, direct care staff T sall out at times, and usur the resident just wanted er and give the resident resident would be fine. Ele/she would document to in the Kiosk and would per M, licensed nursing stational call out at times, but the sident being physical. The ent any behaviors. The staff any behaviors. The staff	viors rsing nurse f staff s and stated ally a Direct he tell aff R did he would were sing r inator s. rsing vas ded. sing	F 280			

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
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F 280	necessary which may quarterly reviews. The facility failed to re- residents care plan to	olicy for care plans plan will be updated as be more often than at	the	F 280				
	- The facility admitted resident #65 on 6/17/15, per the 10/20/15 signed physician's order sheet, with diagnosis of urinary retention (lack of ability to urinate and empty the bladder). Staff recorded in the 6/29/15 urinary incontinence and indwelling catheter CAAS (Care Area Assessment Summary) the resident had an indwelling catheter. The resident's 9/22/15 quarterly Minimum Data							
	Set recorded a BIMS (Brief Interview for Mental Status) score of 12 (a score of 12 indicated moderate cognitive impairment), required extensive assistance of 2 staff for transfers and toilet use, used a wheelchair, and had an indwelling catheter. The resident's 9/29/15 care plan, recorded staff removed the resident's catheter on 9/9/15 and reinserted the catheter on 9/23/15. An intervention dated 9/23/15, directed staff to change the catheter per the physician's order, monitor and chart output every day, and monitor for signs/symptoms of urinary tract infection. The resident's care plan failed to direct staff in the care of the resident's catheter tubing and failed to direct care to apply an anchor to the resident's							

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		` ′	E CONSTRUCTION	(X3) DATE SUR COMPLETE	
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F 280	Continued From pag catheter.	e 13		F 280			
	7:05 AM, the staff recleave the urinary cath	9/23/15 nursing notes, beived a physician's orc neter in place, as the re g and emptying his/her	ler to				
	resident in his/her roc catheter tubing touch wheelchair, in a lengt At 5:01 PM, observat the dining room, in a tubing touched the ca	PM, observation revealed min a wheelchair with ing the floor, under the thof approximately 3 in it ion revealed the reside wheelchair, and the cat arpeted floor under the of approximately 8 inch	the ches. nt in theter				
		AM, the resident verified oe of anchoring device					
		AM, direct care staff L think the resident liked nigh.	the				
	On 10/29/15 at 4:05 PM, direct care staff K stated staff needed to keep the catheter tubing off the floor. On 10/29/15 at 6:07 PM, direct care staff M stated the resident came to the facility from the hospital and never had a leg strap in place.						
			the				
	resident had the cath Licensed staff G repo keep the catheter tub staff G state he/she v	, licensed staff G stated eter for urinary retention orted the staff needed to sing off the floor. Licens was not sure about the requirement of having blace to the catheter.	n. o sed				

		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		I * *	LE CONSTRUCTION	' '	(X3) DATE SURVEY COMPLETED	
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		175385		B. WING	-	11/0	5/2015	
NAME OF PR	NAME OF PROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
ASBURY	PARK		200 SW NEWTO	/ 14TH DN, KS 6711	4			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RECENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 280	Continued From page 14			F 280				
	staff A stated staff neethe floor. He/she add type of anchoring dev On 10/30/15 at 11:01 the floor nurses update needed. Licensed state care plan addressed the catheter as per the not completed updates resident's catheter on On 10/30/15 at 10:20 staff A stated the individual to the resident's. The facility's undated policy recorded the canecessary which may quarterly review. The facility failed to refresident's care plan to treatment of the resident.	AM, licensed staff E state the care plans, as aff E stated the resident the pericare and to char e doctor's orders, but we downer staff reinserted 19/23/15. AM, licensed administrational floor nurses need care plans, as needed. comprehensive care plans be more often than at the care plans at the comprehensive care plans are plans will be updated to be more often than at	off ne ated t's nge vas the rative ded to an I as					
	dated 8-14-15, reveal neuropathy (disease of weakness). The annual MDS (mir 4-7-15, assessed the interview for mental s moderate cognitive definition of the second secon	#2's history and physicalled diagnoses including of the nerves) and mushimum data set), dated resident with a BIMS (tatus) score of 12, indication, required extensivality, transfer, ambulation	cle orief cating e					

		STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
ASBURY PARK 200 SW 14TH NEWTON, KS 67114 CAN ID PREFIX TAG		175385			B. WING		11/05/2015	
F 280 Continued From page 15 dressing, toileting and personal hygiene. This MDS assessed the resident with unstable balance, always continent of bowel and bladder, and sustained no falls since the last assessment. The quarterly MDS (minimum data set), dated 8.4-15, assessed the resident with moderate cognitive impairment, no behaviors, and required supervision for bed mobility, independent for transfer and walking in the room, and supervision for ambulation in hallways. This assessment assessed the resident with a balance steady at all times, no impairment of the upper and lower extremities, and unitized a walker for ambulation. This assessment assessed the resident with resident sustained 2 or more non injury falls and 2 falls with injury since the prior assessment. The CAA (care area assessment) for falls, dated 4-7-15, assessed the resident at risk for falls due	NAME OF PROVIDER OR SUPPLIER ASBURY PARK			200 SW	14TH			
dressing, toileting and personal hygiene. This MDS assessed the resident with unstable balance, only able to stabilize with staff assistance, always continent of bowel and bladder, and sustained no falls since the last assessment. The quarterly MDS (minimum data set), dated 8-4-15, assessed the resident with moderate cognitive impairment, no behaviors, and required supervision for bed mobility, independent for transfer and walking in the room, and supervision for ambulation in hallways. This assessment assessed the resident with a balance steady at all times, no impairment of the upper and lower extremities, and unitized a walker for ambulation. This assessment assessed the resident sustained 2 or more non injury falls and 2 falls with injury since the prior assessment. The CAA (care area assessment) for falls, dated 4-7-15, assessed the resident at risk for falls due	PRÉFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY			PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	JLD BE COMP	PLETION
diabetes, neuropathy, and use of diuretics. The resident used a mobility device and had a stooped forward posture. The care plan, updated 10-2-15, advised the staff to walk the resident to meals with assistance and a walker, with the wheelchair to follow, as needed, to maintain and increase ambulation and endurance. The care plan advised staff to respond promptly to the call light, instruct and encourage the resident to use of the call system and keep items in reach. To keep the bed in a low position and the wheelchair locked when not in use. To keep the room clean, pathways clear, ensure clear access from the bed to the bathroom, monitor for safety hazards, shoes, foot wear on when up, and non skid socks on when in	F 280	dressing, toileting and MDS assessed the rebalance, only able to assistance, always cobladder, and sustained assessment. The quarterly MDS (note as a sessment assessment). The quarterly MDS (note as a sessment as a sessment). The quarterly MDS (note as a sessment as a sessment). The quarterly MDS (note as a sessment as a sessment as a sessment as a sustained and uniting assessed the resident times, no impairment extremities, and uniting assessment as a sustained 2 or more rewith injury since the position and the position and the value of the position and the value o	d personal hygiene. The sident with unstable stabilize with staff continent of bowel and ed no falls since the last minimum data set), date resident with moderate, no behaviors, and required for in the room, and supervively. This assessment with a balance steady of the upper and lower zed a walker for ambulates the resident mon injury falls and 2 fallorior assessment. Assessment) for falls, daresident at risk for falls of falls, depression, and use of diuretics. It is device and had a ure. Bed 10-2-15, advised the personal moderate ambulation increase ambulation and increase ambulations are plan advised staff to the call light, instruct and the use of the call system. To keep the bed in wheelchair locked where oom clean, pathways of from the bed to the resident who are pathways of from the bed to the resident with a pathways of from the bed to the resident with a pathways of from the bed to the resident with a pathways of from the bed to the resident with a pathways of from the bed to the resident with a pathways of from the bed to the resident with a pathways of from the bed to the resident with a pathways of from the bed to the resident with a pathways of from the bed to the resident with a pathway of the pa	ed ed ed uired ryision at at all ation. Ils ated adde The e staff e and an and addetem an anot elear, a, foot	F 280			

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI ND PLAN OF CORRECTION IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	175385			B. WING		11/05/2015	
	OVIDER OR SUPPLIER			ESS, CITY, STA	TE, ZIP CODE		
ASBURY	PARK		200 SW NEWTO	14TH N, KS 6711	4		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE COMPLETION	ON
F 280	bed. However, this caintervention following 10-23-15. Review of the nurses 7:05 am, revealed the assisted into the dinir and gait belt. The resand the resident fell of table, sustaining a rigabrasion, and multiple spots) areas. Observation, on 10-2 the resident seated in resident had sutures was bruised (approximation and the resident had sutures was bruised (approximation and the resident dressed dining room in a wheeling the following room in a wheeling room in	are plan lacked an updathe resident's fall on 'notes, dated 10-23-15 eresident was being an groom, utilizing a walk sident's right knee buck onto the the dining room ght ear laceration, ching e ecchymotic (small pure properties) a his/her recliner. The in their upper right ear, mately 4 centimeters) hin, and had a blue roximately 4 centimeter	e at Rer Eled, In Irple led In the Inthe It.	F 280	DEFICIENCY)		
	the resident ambulate	9-15 at 12:53 pm, rever ed with a walker, in the are staff W. The reside					

	IENT OF DEFICIENCIES AN OF CORRECTION (X1) PROVIDER/SUPPLIEF IDENTIFICATION NUM					(X3) DATE SURVEY COMPLETED	
	175385			B. WING		11/05/2015	
	OVIDER OR SUPPLIER			RESS, CITY, STA	TE, ZIP CODE		
ASBURY	PARK		200 SW NEWTO	14TH N, KS 6711	4		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION	
F 280	had a gait belt on and took slow steps, the versident. Interview, on 10-29-1 resident, revealed the early in the morning, not allow enough time before getting dresse room. The resident's get up between 7:30 stime to fully awaken be day and ambulating. Interview, on 10-30-1 nursing staff E, revea whose shift the resideresponsible for updatic confirmed the lack of resident's fall on 10-2. Interview, on 10-30-1 administrative nursing intervention for the fatherapy for strengthed did not have an immediate resident safe. The facility policy for 10/2015, advised staffall, the staff will re-exconsider other possib falling and will re-eval relevance of current in the facility failed to resident to the resident to the facility failed to resident to the facility failed to resident to the facility failed to resident faill, the staff will re-eval relevance of current in the facility failed to resident faill, the staff will re-eval relevance of current in the facility failed to resident faill.	d was leaning forward at wheelchair was not beh. 5 at 2:30 pm, with the e fall on 10-23-15, occurand the resident felt state for him/her to awaken d and ambulate to the ottated he/she would pream and 8:00 am, and a pefore getting ready for 5 at 1:00 pm, with licentled the charge nurse of ent had fallen, was ing the care plan, and an update completed for 3-15. 5 at 1:15 pm, with g staff C, revealed the ll was to consult physical management, revise fall management, revise fall management, revise fif if the resident continued and the reasons for the residuate the continued interventions.	rred aff did dining fer to illow the ased n or the al cility tep ed es to d lent's	F 280			

Printed: 11/05/2015 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1, ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	175385			B. WING 11/05/2			5/2015
NAME OF PR	OVIDER OR SUPPLIER PARK		200 SW	ESS, CITY, STA 14TH N, KS 6711	,	·	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 280	- Review of resident progress note, dated of macular degenerat deterioration of the re (breaking down of the failure (inability of the concentrate urine and lyphedema (swelling lymph) to the right low psychosis (progressive characterized by failing major mental disorder impairment in reality the sadness, worthlessness, worthlessnessness, worthlessnessness, worthlessnessnessnessness, worthlessnessnessnessnessnessnessnessnessness	#60's signed physician 9-12-15, included diagrion (progressive tina), spondylolysis evertebra) chronic renakidneys to excrete was disconserve electrolytes) caused by accumulation were extremity, dementiate mental disordering memory, confusion, ar characterized by a growing memory, confusion, and emptiness) and emptiness) and emptiness) and emptiness in the resident with a BIMS tatus) score of 13 indicated as independent with a score or lower extremities, the regular extremities are the last assessment. The session of the session of the resident's balance as the last assessment. The session of the session of the last assessment of the last assessment. The session of the session of the last assessment with his dent was independent, decline in physical health decline in physical health as a session of the last assessment.	al stes, , , n of with any oss and (brief ating or stition e to s/her at th,	F 280			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION LIBERTIFICATION NUMBER 1		IDENTIFICATION NUMBE	IX.	A. BOILDING		COMPLE	.1L <i>U</i>	
		175385		B. WING		11/	05/2015	
NAME OF PF	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE	•		
ASBURY PARK			200 SW NEWTO	14TH ON, KS 6711	4			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATO OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 280	Continued From page 19			F 280				
	resident was unable to straight due to scoliose curvature of the spine visually check the resident properties. Staff was forgets to use the wal Staff should promptly light, keep the room of from the bed to the back hazards shoes, footwooks on when in bed. Review of the facility's sustained 8-12-15 through the lack of nother than adding ten on 10-8-15. Observation, on 10-2 the resident alert to prochair in his/her room. between the bed and The resident had an expurple spots) on the bed surring approximate centimeter purple fluid interview, on 10-27-1 nursing staff Z, reveat several days ago and his/her right leg and sprobably a result of the resident did should have independently. Staff	s fall analysis for falls rough 10-27-15 (6 falls), rew interventions addednis balls to the walker of the resident's walker of the resident's walker of the rocking chair foot recchymotic area (small back of his/her right legately 6 centimeter with a dilled blister. 5 at 3:15 pm, with licer led the resident had fall sustained a bruise to t	n and o e a ong ten m, call ess fety kid ed cking sat est.					

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175385 B. WII			B. WING	WING 11/0		
				TE, ZIP CODE		
ASBURY PARK				4		
(EACH DEFICIENCY MUS	T BE PRECEDED BY FULL RE		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	OULD BE	(X5) COMPLETION DATE
resident to maintain in Interview, on 10-29-1 care staff Y revealed his/her room indepens taff should offer star stated the resident dilight, and sometimes. Interview, on 10-29-1 nursing staff G, reveal episodes of confusion light for assistance. Salid out of his/her low not sustain any injury Staff G explained that care care plan should at the time of each fall Interview, on 10-30-1 administrative nursing interventions for this resident's mood and intervention. Staff C reviewed, and the far plan meetings, but stresident from sustain due to the resident's The facility failed to recare with intervention resident at risk for fall falls.	sat 8:45 am, with direct the resident ambulated idently with the walker, and by assistance. Staff d not always use the car was resistive to care. 5 at 4:14 pm, with liceraled the resident did han and did not use his/he Staff G stated the resid v bed on 10-14-15, and v. 1 new interventions to the distance of the interventions to the staff C, revealed the resident depended on the willingness for staff explained the care plarmily participated in the carategies for keeping the ing accidents was difficumental status. Eview and revise the plans timely to ensure this lis, did not sustain repeated.	I in but Y all ased ve er call ent did he plan he an was care e cult an of ated	F 280			
had a BIMS (brief inte	erview for mental status					
	Continued From page resident to maintain in Interview, on 10-29-1 care staff Y revealed his/her room indepension staff should offer start stated the resident dilight, and sometimes. Interview, on 10-29-1 nursing staff G, reveal episodes of confusion light for assistance. Side out of his/her low not sustain any injury Staff G explained that care care plan should at the time of each fall Interview, on 10-30-1 administrative nursing interventions for this resident's mood and intervention. Staff C reviewed, and the far plan meetings, but st resident from sustain due to the resident's The facility failed to recare with intervention resident at risk for fall falls.	OVIDER OR SUPPLIER PARK SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL RE OR LSC IDENTIFYING INFORMATION) Continued From page 20 resident to maintain independence. Interview, on 10-29-15 at 8:45 am, with direct care staff Y revealed the resident ambulated his/her room independently with the walker, staff should offer stand by assistance. Staff stated the resident did not always use the callight, and sometimes was resistive to care. Interview, on 10-29-15 at 4:14 pm, with licer nursing staff G, revealed the resident did ha episodes of confusion and did not use his/he light for assistance. Staff G stated the resid slid out of his/her low bed on 10-14-15, and not sustain any injury. Staff G explained that new interventions to tare care plan should be added to the care at the time of each fall. Interview, on 10-30-15 at 1:15 pm, with administrative nursing staff C, revealed the interventions for this resident depended on the resident's mood and willingness for staff intervention. Staff C explained the care plan reviewed, and the family participated in the oplan meetings, but strategies for keeping the resident from sustaining accidents was difficult to the resident's mental status. The facility failed to review and revise the plan reviewed in the resident from sustaining accidents was difficult to the resident at risk for falls, did not sustain repeting falls.	TOURIDER OR SUPPLIER PARK SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 20 resident to maintain independence. Interview, on 10-29-15 at 8:45 am, with direct care staff Y revealed the resident ambulated in his/her room independently with the walker, but staff should offer stand by assistance. Staff Y stated the resident did not always use the call light, and sometimes was resistive to care. Interview, on 10-29-15 at 4:14 pm, with licensed nursing staff G, revealed the resident did have episodes of confusion and did not use his/her call light for assistance. Staff G stated the resident slid out of his/her low bed on 10-14-15, and did not sustain any injury. Staff G explained that new interventions to the care care plan should be added to the care plan at the time of each fall. Interview, on 10-30-15 at 1:15 pm, with administrative nursing staff C, revealed the interventions for this resident depended on the resident's mood and willingness for staff intervention. Staff C explained the care plan was reviewed, and the family participated in the care plan meetings, but strategies for keeping the resident from sustaining accidents was difficult due to the resident's mental status. The facility failed to review and revise the plan of care with interventions timely to ensure this resident at risk for falls, did not sustain repeated falls. - The annual MDS (minimum data set), dated 6/9/15, for resident #33, revealed the resident had a BIMS (brief interview for mental status)	A BUILDING 175385 OVIDER OR SUPPLIER PARK SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 20 resident to maintain independence. Interview, on 10-29-15 at 8:45 am, with direct care staff Y revealed the resident ambulated in his/her room independently with the walker, but staff should offer stand by assistance. Staff Y stated the resident did not always use the call light, and sometimes was resistive to care. Interview, on 10-29-15 at 4:14 pm, with licensed nursing staff G, revealed the resident did have episodes of confusion and did not use his/her call light for assistance. Staff G stated the resident slid out of his/her low bed on 10-14-15, and did not sustain any injury. Staff G explained that new interventions to the care care plan should be added to the care plan at the time of each fall. Interview, on 10-30-15 at 1:15 pm, with administrative nursing staff C, revealed the interventions for this resident depended on the resident's mood and willingness for staff intervention. Staff C explained the care plan was reviewed, and the family participated in the care plan meetings, but strategies for keeping the resident from sustaining accidents was difficult due to the resident's mental status. The facility failed to review and revise the plan of care with interventions timely to ensure this resident at risk for falls, did not sustain repeated falls. - The annual MDS (minimum data set), dated 6/9/15, for resident #33, revealed the resident had a BIMS (brief interview for mental status)	DOUBER OR SUPPLIER PARK SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY) MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 20 resident to maintain independence. Interview, on 10-29-15 at 8:45 am, with direct care staff Y revealed the resident ambulated in his/her room independently with the walker, but staff should offer stand by assistance. Staff Y stated the resident did not always use the call light, and sometimes was resistive to care. Interview, on 10-29-15 at 4:14 pm, with licensed nursing staff G, revealed the resident slid out of his/her low bed on 10-14-15, and did not sustain any injury. Staff G explained that new interventions to the care care plan should be added to the care plan at the time of each fall. Interview, on 10-30-15 at 1:15 pm, with administrative nursing staff C, revealed the interventions for this resident depended on the resident's mood and willingness for staff intervention. Staff C explained the care plan meetings, but strategies for keeping the resident from sustaining accidents was difficult due to the resident's mental status. The facility failed to review and revise the plan of care with interventions timely to ensure this resident at risk for falls, did not sustain repeated falls.	TOWNER ON SUPPLIER 175385 SUND STREET ADDRESS, CITY, STATE, ZIP CODE 200 SW 14TH NEWTON, KS 67114 SUMMARY STATEMENT OF DEPICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH DEPICIENCY MUST BE A 8.45 am, with direct care staff Y revealed the resident ambulated in his/her room independence. Interview, on 10-29-15 at 8.45 am, with direct care staff Y revealed the resident ambulated in his/her room independently with the walker, but staff should offer stand by assistance. Staff Y stated the resident did not always use the call light, and sometimes was resistive to care. Interview, on 10-29-15 at 4.14 pm, with licensed nursing staff G, revealed the resident did have episodes of confusion and did not use his/her call light for assistance. Staff G stated the resident shid use his/her call light for assistance. Staff G stated the resident shid use his/her call right for assistance. Staff G stated the resident shid use his/her call light for assistance. Staff G explained that new interventions to the care plan should be added to the care plan at the time of each fall. Interview, on 10-30-15 at 1:15 pm, with administrative nursing staff C, revealed the intervention. Staff C explained the care plan was reviewed, and the family participated in the care plan meetings, but strategies for keeping the resident from sustaining accidents was difficult due to the resident's mental status. The facility failed to review and revise the plan of care with interventions timely to ensure this resident at risk for falls, did not sustain repeated falls.

	MENT OF DEFICIENCIES AN OF CORRECTION (X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMB					(X3) DATE SURVEY COMPLETED	
	175385			B. WING		11/0	05/2015
NAME OF PR	OVIDER OR SUPPLIER PARK		200 SW	ESS, CITY, STA 14TH N, KS 6711			
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIENCY MUS OR LSC ID		ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 280	resident required limit of 2 staff. The CAA (care area a (activities of daily living the resident required He/she required assist The care plan, review guidance for the use resident's bed. Review of the side ra 10/20/15, revealed the quarter rails on each repositioning and sitting On 10/28/2015 at 3:4 stated the resident's resident's bed a coup he/she tried to grab the bed to help with turning On 10/29/2015 at 9:0 he/she used the side was helping with chather on 10/29/2015 at 10:1 stated the side rails were sident with bed more provided. On 10/29/2015 at 10:1 stated the resident with resident was incontinent care. On 10/30/2015 at 10:1 nursing staff S, stated	assessment) for ADLs assessment) for ADLs ag), dated 6/9/15, reve assistance with ADLs. stance with bed mobility and on 9/15/15, lacked of the side rails on the ail usage assessment, do a resident wanted the taside up, for assistance ing up in the bed. 12 PM, direct care staff side rails were applied on the side up, for assistance ing up in the bed. 12 PM, direct care staff side rails were applied on the side of weeks ago. At night be book case located bing. 13 AM, the resident exprail to hold onto when a niging his/her briefs at resident care staff.	aled y. ated op with P, to the ht, y the lained staff hight. f O, s	F 280			
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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		` ′	CONSTRUCTION	(X3) DATE S COMPL		
		175385		B. WING		11	/05/2015	
NAME OF PROVIDER OR SUPPLIER ASBURY PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 200 SW 14TH NEWTON, KS 67114					
(X4) ID PREFIX TAG	(EACH DEFICIENCY M	Y STATEMENT OF DEFICIENCIES UST BE PRECEDED BY FULL RE : IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
	change of status, a care plan. The adn verified the care plathe side rails. On 10/30/2015 at a nursing staff A, staresponsible to update the care plans revealed resident's health not the care plan wou which may be more than to include the resident who require mobility. 483.25(d) NO CAT RESTORE BLADD Based on the resident who enterindwelling catheter resident's clinical catheterization was who is incontinent treatment and servinfections and to refunction as possible This Requirement.	and were documented in the ininistrative nursing staff Stan lacked documentation. 10:19 AM, administrative ted each nurse was attented the care plan as needed and policy for comprehensed the plan indicated the eeds, problems, and conducted by a confer than at quarterly represent the each of side rails for this area assistance with bed the entity must ensure that a standard the entity without an is not catheterized unless ondition demonstrates the entity of bladder receives appropriates to prevent urinary transfer as much normal blates.	ed. ive itions. ary eview. are s the at nt priate act adder	F 280				
	identified 7 resident catheters. The sar one resident (#65)	ensus of 97 residents and its with indwelling urinary inple of 23 residents inclu- with an indwelling urinary in observation, interview, a	ded ,					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER					(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBE	R:	A. BUILDING		COMPLET	ED
	175385			B. WING		11/0	5/2015
NAME OF PR	NAME OF PROVIDER OR SUPPLIER S'		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ASBURY	PARK		200 SW				
			NEWTO	ON, KS 6711	4		
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F 315	Continued From page	e 23		F 315			
	record review, the factorization appropriate treatment urinary tract infections		a, for				
	per the 10/20/15 sign with diagnosis of urinate our empty. Staff recorded in the cand indwelling catheter.	6/29/15 urinary incontin	eet, oility				
	Set, recorded a BIMS Status) score of 12 (a moderate cognitive in extensive assistance toilet use, used a whe indwelling catheter. The resident's 9/29/19 removed the resident reinserted the cathete intervention dated 9/2 change the catheter pmonitor and chart out for signs/symptoms of Staff recorded in the 97:05 AM, received phurinary catheter in pla	of 2 staff for transfers a celchair, and had an 5 care plan, recorded s 's catheter on 9/9/15 ar	ntal and taff nd r, nitor at the				
	-	PM, observation reveale					

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMB			` ′	LE CONSTRUCTION	(X3) DATE S COMPL	
			B. WING		11	/05/2015	
NAME OF PROVIDER OR SUPPLIER ASBURY PARK			200 SW	RESS, CITY, STA 14TH N, KS 6711			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL RE OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 315	resident in his/her recatheter tubing direct the wheelchair, in a inches. At 5:01 PM resident in the dinin the catheter tubing floor under the wheel approximately 8 inc. On 10/29/15 at 8:22 he/she lacked any to place to secure the with urethral trauma. On 10/29/15 at 10:1 stated he/she did not leg strap on his/her. On 10/29/15 at 4:05 staff needed to keep floor. On 10/29/15 at 6:07 stated the resident of hospital and never hospital and never hospital and never to the catheter tubicensed staff G was policy for the required device in place to the total staff A stated staff in the floor. He/she act type of anchoring device in place to the cathetering of the resident of the floor. He/she act type of anchoring device in place to the cathetering of the required points at the floor. He/she act type of anchoring device in place to the catheter in the floor. He/she act type of anchoring device in place to the catheter in the floor. He/she act type of anchoring device in place to the catheter in the floor. He/she act type of anchoring device in place to the catheter in the floor. He/she act type of anchoring device in place to the catheter in the floor. He/she act type of anchoring device in place to the catheter in the floor.	coom in a wheelchair with ctly touching the floor, ur length of approximately lobservation revealed the groom, in a wheelchair, directly touched the carpelchair, in length of hes. 2 AM, the resident verified ype of anchoring device catheter from potential plate. 30 AM, direct care staff Length of think the resident liked thigh. 31 PM, direct care staff K is perfect the catheter tubing off of the catheter tubing off of the catheter for urinary retention plained the staff needed ubing off the floor. Howe is not sure about the facilement of having an ancher in the catheter for urinary and the catheter for urinary and the staff needed ubing off the floor. Howe is not sure about the facilement of having an ancher in the catheter for urinary and the facilement of having an ancher in the catheter for urinary and the facilement of having an ancher in the catheter for urinary and the facilement of having an ancher in the catheter for urinary and the facilement of having an ancher in the catheter for urinary and the facilement of having an ancher in the catheter for urinary and the facilement of having an ancher in the catheter for urinary and the facilement of having an ancher in the catheter for urinary and the facilement of having an ancher in the catheter for urinary and the	der 3 ale and eted d in ulling the stated of the the the the n. to ver, lity's oring rative g off me	F 315			

STATEMENT	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		LIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SUF	(X3) DATE SURVEY	
AND PLAN O	PLAN OF CORRECTION IDENTIFICATION NUMBER:		R:	A. BUILDING		COMPLETED		
		175385		B. WING		11/0	5/2015	
NAME OF PR	ME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
ASBURY	PARK		200 SW					
				ON, KS 6711	4			
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F 315	Continued From page	e 25		F 315				
	Edition, directed staff to secure the indwelling catheter to the resident's thigh using tape, strap, adhesive anchor or other securement device to reduce pressure on the urethra exerted by the catheter. Allow some slack of the tubing to accommodate the resident's movements. The facility's undated policy for urinary continence and incontinence recorded if an indwelling catheter was needed, staff needed to anchor the tubing to secure the catheter tubing and keep the tubing off the floor. The facility failed to provide the appropriate treatment and services for this resident with an indwelling catheter, as staff failed to ensure the catheter tubing remained off the floor and failed to provide an anchoring device to the catheter to							
	provide an anchoring device to the catheter to prevent possible trauma to the base of the bladder. 3 483.25(h) FREE OF ACCIDENT		lo	F 323				
SS=D	The facility must ensu environment remains as is possible; and ea	re that the resident as free of accident haz						
	The facility reported a The sample of 23 res for accidents. Based and record review, the	not met as evidenced be census of 97 residents idents included 3 review on observation, interview facility failed to ensure sampled residents time ent repeated falls.	ved ew, e 2					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1 ' '	E CONSTRUCTION	(X3) DATE S COMPLI	
		175385		B. WING		11/	/05/2015
NAME OF PROVIDER OR SUPPLIER ASBURY PARK			200 SW	RESS, CITY, STAT 14TH N, KS 6711			
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F 323	Findings included: Review of resident dated 8-14-15, revea neuropathy (disease weakness. The annual MDS (mi 4-7-15, assessed the interview for mental smoderate cognitive dassistance with mobi dressing, toileting an MDS assessed the rebalance, only able to assistance, always obladder, and sustaine assessment. The quarterly MDS (ii 8-4-15, assessed the cognitive impairment supervision for bed in transfer and walking for ambulation in hall assessed the resider times, no impairment extremities, and uniti This assessment assistained 2 or more with injury since the part of the cognitive impairment extremities, and uniti the company of the cognitive impairment extremities, and uniti the company of the cognitive impairment extremities, and uniti the company of the cognitive impairment extremities, and uniti the company of the cognitive impairment extremities, and uniti the company of the cognitive impairment extremities, and uniti the company of the cognitive impairment extremities, and uniti the company of the cognitive impairment extremities, and uniti the cognitive impairment extremities in the cognitiv	#2's history and physicaled diagnoses including of the nerves) and must inimum data set), dated a resident with a BIMS (status) score of 12, indicate (status) score of 13, indicate (status) score of 14, indicate (status) score of 15, indicate (stat	brief cating e n, nis t ed ed evision tt v at all eation. lls atted s due The	F 323			

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				LE CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
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						11/0	15/2015	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE		
F 323	Continued From page	e 27		F 323				
1 323	to walk the resident to a walker, with the who needed, to maintain a endurance. The care respond promptly to the encourage the reside and keep items in real low position and the win use. To keep the reensure clear access of bathroom, monitor for wear on when up, and bed. Review of the nurses of 7:05 am, revealed the	o meals with assistance elechair to follow, as and increase ambulation plan advised staff to the call light, instruct an ant to use of the call system. To keep the bed in wheelchair locked when soom clean, pathways come the bed to the esafety hazards, shoes do non skid socks on wheelchair locked when some clean, pathways come the bed to the esafety hazards, shoes do non skid socks on wheelchair locked when safety hazards, shoes do non skid socks on wheelchair locked when safety hazards, shoes do non skid socks on wheelchair locked was being	n and d tem a not lear, foot en in	7 020				
	7:05 am, revealed the resident was being assisted into the dining room, utilizing a walker and gait belt. The resident's right knee buckled, and the resident fell onto the the dining room table, sustaining a right ear laceration, chin abrasion, and multiple ecchymotic (small purple spots) areas.							
	the resident seated in resident had sutures i was bruised (approxin underneath his/her ch ecchymotic area appr	in their upper right ear, mately 4 centimeters) nin, and had a blue oximately 4 centimeter	and					
	his/her anterior left hand. Observation, on 10-29-15 at 7:15 am, revealed the resident dressed appropriately, seated in the dining room in a wheelchair, eating breakfast. Interview, on 10-29-15 at 7:15, am, with direct care staff L, revealed the resident required assistance with all activities of daily living, and did use his/her call light. Staff L stated the resident did not wish to ambulate this morning. Staff L							

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA				LE CONSTRUCTION	, ,	(X3) DATE SURVEY	
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F 323	stated the resident did during ambulation to some linterview, on 10-29-12 care staff X, revealed assistance with gait, at Observation, on 10-29 the resident ambulate hallway, with direct can had a gait belt on and took slow steps, the withe resident. Interview, on 10-29-12 resident, revealed the early in the morning, anot allow enough time before getting dresser room. The resident's get up between 7:30 at time to fully awaken be day and ambulating. Interview, on 10-30-12 nursing staff E, revea whose shift the resider responsible for updatic confirmed the lack of resident's fall on 10-2 linterview, on 10-30-13 administrative nursing intervention for the fall therapy for strengther did not have an immediate resident safe. The facility policy for the facility poli	d require cueing for positive to the walker of the resident required and did use the call light of the resident required and did use the call light of the resident required and did use the call light of the resident resident resident was leaning forward a wheelchair was not behind the resident felt state of the resident for the resident felt of the care plan, and an update completed for 3-15. The resident required the resident felt state of the res	ct t. aled nt nd ind ind dining fer to llow the sed n or the al cility ep	F 323				
		f if the resident continu						

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED	,	
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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		
ASBURY PARK 200 SW 14TH NEWTON, KS 67114		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY TAG OR LSC IDENTIFYING INFORMATION) TAG OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323 Continued From page 29 fall, the staff will re-evaluate the situation and consider other possible reasons for the resident's falling and will re-evaluate the continued relevance of current interventions. The facility falled to ensure timely interventions following a fall to prevent repeated falls for this resident. - Review of resident #60's signed physician progress note, dated 9-12-15, included diagnoses of macular degeneration (progressive deterioration of the retina), spondylolysis (breaking down of the vertebra) chronic renal failure (inability of the kidneys to excrete wastes, concentrate urine and conserve electrolytes), lyphedema (swelling caused by accumulation of lymph) to the right lower extremity, dementia with psychosis (progressive mental disorder characterized by falling memory, confusion, any major mental disorder characterized by a gross impairment in reality testing), depression (of sadness, worthlessness and emptiness) and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear). The annual MDS (minimum data set), dated 2-17-15, assessed the resident with a BIMS (brief interview for mental status) score of 13 indicating intact cognitive status (13-15). This MDS assessed the resident was independent with transfers and mobility, required supervision for dressing and toilet use, required extensive assistance with personal hygiene, and no impairment in the upper or lower extremities. This MDS assessed the resident's balance as steady at all times, used a walker for ambutation		

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE	
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F 323	Continued From page	e 30		F 323		
	not wanting or allowin daily cares. The residence risk for falls due to a consist with the use of psychological properties.	living, dated 2-17-15, it as at risk for injury du ig staff to assist with his dent was independent, decline in physical heal	s/her at th,			
	The care plan, updated 8-11-15, advised staff the resident was unable to stand up completely straight due to scoliosis/kyphosis (breakdown and curvature of the spine). Staff were advised to visually check the resident on rounds before bedtimes, and encourage the resident to use a walker for ambulation and a wheelchair for long distances. Staff was advised the resident often forgets to use the walker when in his/her room, Staff should promptly answer the resident's call light, keep the room clean, ensure clear access from the bed to the bathroom, monitor for safety hazards shoes, footwear when up and nonskid socks on when in bed.					
	Review of the facility's fall analysis for falls sustained 8-12-15 through 10-27-15 (6 falls), revealed the lack of new interventions other than adding tennis balls to the walker dated on 10-8-15.					
	Observation, on 10-27-15 at 3:10 pm, revealed the resident alert to person, seated in the rocking chair in his/her room. The resident's walker sat between the bed and the rocking chair foot rest. The resident had an ecchymotic area (small purple spots) on the back of his/her right leg measuring approximately 6 centimeter with a 3 centimeter purple fluid filled blister.		cking sat est.			

F 323 Continued From page 31 Interview, on 10-27-15 at 3:15 pm, with licensed nursing staff Z, revealed the resident had fallen several days ago and sustained a bruise to the his/her right leg and stated the blister was	ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	` /	.iA	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
ASBURY PARK (X4) ID PREFIX TAG F 323 Continued From page 31 Interview, on 10-27-15 at 3:15 pm, with licensed nursing staff Z, revealed the resident had fallen several days ago and sustained a bruise to the his/her right leg and stated the blister was		175385	175385 B. WING		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 323 Continued From page 31 Interview, on 10-27-15 at 3:15 pm, with licensed nursing staff Z, revealed the resident had fallen several days ago and sustained a bruise to the his/her right leg and stated the blister was		21.01.00112.21.	200 SW 14TH	,	
Interview, on 10-27-15 at 3:15 pm, with licensed nursing staff Z, revealed the resident had fallen several days ago and sustained a bruise to the his/her right leg and stated the blister was	REFIX (EACH DEFICIENCY MUST	EACH DEFICIENCY MUST BE PRECEDED BY FULL REGUL	SULATORY PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	LD BE COMPLETION
resident did should have staff supervision in his/her room, but often was found to ambulate independently. Staff Z stated the resident was confused at times, but the family wanted the resident to maintain independence. Interview, on 10-29-15 at 8:45 am, with direct care staff Y revealed the resident ambulated in his/her room independently with the walker, but staff should offer stand by assistance. Staff Y stated the resident did not always use the call light, and sometimes was resistive to care. Interview, on 10-29-15 at 4:14 pm, with licensed nursing staff G, revealed the resident did have episodes of confusion and did not use his/her call light for assistance. Staff G stated the resident sid out of his/her low bed on 10-14-15, and did not sustain any injury. Staff G explained that new interventions to the care care plan should be added to the care plan at the time of each fall. Interview, on 10-30-15 at 1:15 pm, with administrative nursing staff C, revealed the interventions for this resident depended on the resident's mood and willingness for staff intervention. Staff C explained the care plan was reviewed, and the family participated in the care plan meetings, but strategies for keeping the resident from sustaining accidents was difficult due to the resident's mental status. The facility failed to ensure timely interventions	Interview, on 10-27-15 nursing staff Z, reveal several days ago and his/her right leg and st probably a result of the resident did should hat his/her room, but ofter independently. Staff Z confused at times, but resident to maintain in Interview, on 10-29-15 care staff Y revealed this/her room independent staff should offer stand stated the resident did light, and sometimes with the resident did light, and sometimes with the resident did light for assistance. So slid out of his/her low not sustain any injury. Staff G explained that care care plan should at the time of each fall Interview, on 10-30-15 administrative nursing interventions for this reresident's mood and wintervention. Staff C ereviewed, and the famplan meetings, but stratesident from sustaining due to the resident's model.	erview, on 10-27-15 at 3:15 pm, with license rying staff Z, revealed the resident had fallen yeral days ago and sustained a bruise to the /her right leg and stated the blister was shably a result of the bruise. Staff Z stated the dident did should have staff supervision in /her room, but often was found to ambulate ependently. Staff Z stated the resident was not staff at times, but the family wanted the dident to maintain independence. Berview, on 10-29-15 at 8:45 am, with direct re staff Y revealed the resident ambulated in /her room independently with the walker, but ff should offer stand by assistance. Staff Y ted the resident did not always use the call not, and sometimes was resistive to care. Berview, on 10-29-15 at 4:14 pm, with licensed resident of the for assistance. Staff G stated the resident did have stand so for confusion and did not use his/her can for assistance. Staff G stated the resident do out of his/her low bed on 10-14-15, and did at sustain any injury. But G explained that new interventions to the recare plan should be added to the care plan the time of each fall. Berview, on 10-30-15 at 1:15 pm, with ministrative nursing staff C, revealed the erventions for this resident depended on the dident's mood and willingness for staff ervention. Staff C explained the care plan was riewed, and the family participated in the care in meetings, but strategies for keeping the dident from sustaining accidents was difficult the tothe resident's mental status.	sed en he the ess in hout f I sed ee r call nt did ee lan		

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(X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING _ COMPLETED AND PLAN OF CORRECTION 175385 B. WING 11/05/2015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **ASBURY PARK** 200 SW 14TH **NEWTON, KS 67114** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE DATE OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 323 F 323 Continued From page 32 were in place to ensure this resident at risk for falls, did not sustain repeated falls. 483.35(i) FOOD PROCURE, F 371 SS=E STORE/PREPARE/SERVE - SANITARY The facility must -(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This Requirement is not met as evidenced by: The facility had a census of 97 residents. Based on observation, interview, and record review, the facility failed to store food under sanitary conditions in 5 of the 9 facility's kitchens and in 1 of the 2 facility's kitchenettes. Findings included: - Review of the facility's 9 kitchens and 2 kitchenettes revealed the following areas/items of concern: 1) On 10/27/15 at 8:08 AM, observation in one of the kitchens revealed 5 wooden cabinets with porous shelves where the following items were stored: bagged cereal, waffle mix, napkins, Styrofoam and plastic cups. This porous shelf created a surface not easily sanitized. 2) On 10/27/15 at 11 AM, one of the two kitchenettes revealed the following outdated food items:

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		175385		B. WING		11/0	5/2015
ASBURY PARK 20			200 SW	14TH N, KS 67114	,	·	
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F 371	b) A piece of fried of labeled with a resider "10/21". c) A gallon of 2% m remaining in the control of 10/26/15. d) A gallon of unope expiration date of 9/16 e) A Styrofoam box with a resident's name f) An opened contain foil covering pulled be and date of 10/26. g) Six slices of where of 10/14/15. h) A whole loaf of where date of 10/29/15. i) Graham crackers used by 10/3/15. j) Two packages of label which read best which read best which read best container of cottage of date of 10/24/15 and services and services are container of cottage of date of 10/24/15 and services are sides.	hicken in a plastic baggint's name and a date of ilk, with 1/4 of the milk ainer, with an expiration ened 2% milk, with an 8/15. with food items, labele e and lacked a date. Iner of boost plus, with ack, and a resident's name at bread with expiration with label which read by 8/28/15. wheat crackers with	d the ime on date on pest	F 371			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
175385 B. WING	11/05/2015
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
ASBURY PARK 200 SW 14TH NEWTON, KS 67114	
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F 371		etore food under sanitary reas to prevent food bot		F 371			